



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BOARD OF NURSING HOME ADMINISTRATORS
APPLICATION FOR LICENSURE

Please type or print in ink and return to:
Missouri Department of Health and Senior Services
Board of Nursing Home Administrators
P.O. Box 570, Fee Receipts
Jefferson City, MO 65102

I. IDENTIFYING INFORMATION

1. NAME		LAST	FIRST	MIDDLE			
2. ADDRESS - HOME		STREET	CITY	COUNTY	STATE	ZIP CODE	
ADDRESS - BUSINESS		STREET	CITY	COUNTY	STATE	ZIP CODE	
3. TELEPHONE NUMBER			ALL CORRESPONDENCE WILL BE ADDRESSED TO YOUR HOME UNLESS YOU NOTIFY US DIFFERENTLY. YOU ARE REQUIRED TO NOTIFY THIS OFFICE OF ANY CHANGE OF HOME OR BUSINESS ADDRESS WITHIN 21 DAYS OF THE CHANGE 19 CSR 73-2.130				
HOME		BUSINESS					
4. SOCIAL SECURITY NUMBER*		5. DATE OF BIRTH		6. PLACE OF BIRTH		CITY	STATE

II. RECIPROCITY INFORMATION

1. HAVE YOU EVER APPLIED FOR A NURSING HOME ADMINISTRATOR LICENSE IN ANY STATE? ☐ YES ☐ NO
IF YES, AND LICENSE **NOT** ISSUED, PLEASE EXPLAIN BELOW.

IF YES, AND LICENSE ISSUED

STATE	DATE OF LICENSURE	LICENSE NUMBER	STATUS (CURRENT, EXPIRED, ETC.)

III. OTHER PROFESSIONAL LICENSES

1. DO YOU NOW HOLD, OR HAVE YOU EVER HELD, A LICENSE FROM ANY OTHER PROFESSIONAL BOARD IN THIS OR ANY OTHER STATE? IF YES, COMPLETE THE FOLLOWING ☐ YES ☐ NO

STATE	TYPE OF LICENSE	LICENSE NO.	DATE ISSUED	STATUS

2. HAVE ANY OF YOUR PROFESSIONAL LICENSES LISTED ABOVE EVER BEEN DISCIPLINED? ☐ YES ☐ NO
IF YES, EXPLAIN AND ATTACH A COPY OF ANY SETTLEMENT AGREEMENT, CONTRACT, ETC. THAT YOU ENTERED AT THE TIME OF THE DISCIPLINE.

IV. CRIMINAL RECORD

1. HAVE YOU EVER BEEN CHARGED WITH, ARRESTED FOR, OR CONVICTED OF AN OFFENSE INVOLVING THE OPERATION OF A NURSING HOME OR OTHER HEALTH CARE FACILITY? IF YES, ATTACH EXPLANATION. ☐ YES ☐ NO
2. HAVE YOU EVER BEEN CHARGED WITH, ARRESTED FOR, OR CONVICTED OF A CRIME, AN ESSENTIAL ELEMENT OF WHICH IS DISHONESTY, FRAUD OR MORAL TURPITUDE? IF YES, ATTACH EXPLANATION. ☐ YES ☐ NO
3. I HEREBY AUTHORIZE, BY MY NOTARIZED SIGNATURE ON PAGE 4 OF THIS APPLICATION, THE BOARD OF NURSING HOME ADMINISTRATORS TO CONDUCT A RECORD CHECK ON ME, AN APPLICANT FOR LICENSURE, INCLUDING THE RELEASE OF ANY CLOSED RECORDS THAT MAY BE RELEVANT TO CHAPTER 344., RSMo, FOR THE PURPOSE OF CONSIDERING MY QUALIFICATIONS FOR LICENSURE (INCLUDING ARRESTS, CHARGES, INDICTMENTS AND CONVICTIONS). IF NO, PLEASE ☐ YES ☐ NO
ATTACH EXPLANATION

HEIGHT	WEIGHT	COLOR OF HAIR	EYES
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ATTACH PHOTOGRAPH
HERE

* WE ARE REQUESTING THAT YOU VOLUNTARILY PROVIDE YOUR SOCIAL SECURITY NUMBER UNDER THE AUTHORITY OF SECTION 344, RSMo, SUPP. 1990. FAILURE OR REFUSAL TO PROVIDE YOUR SOCIAL SECURITY NUMBER WILL NOT AFFECT LICENSING OR ANY OTHER BENEFITS OR PRIVILEGES YOU WOULD OTHERWISE ENJOY. IF PROVIDED, YOUR SOCIAL SECURITY NUMBER WILL BE USED FOR THE FOLLOWING PURPOSES: A) TO IDENTIFY YOU IN RECORD KEEPING AND INFORMATION EXCHANGES WITH STATE AGENCIES (MISSOURI AND OTHER STATES), FEDERAL AGENCIES AND OTHER DATA SOURCES: B) TO MAKE CRIMINAL HISTORY CHECKS AND TO VERIFY ALL INFORMATION PROVIDED IN THE APPLICATION. DISCOVERY OF FALSE INFORMATION IN THE APPLICATION OR DISCOVERY OF RELEVANT CRIMINAL HISTORY MAY RESULT IN DENIAL OF YOUR APPLICATION.

BOARD OF NURSING HOME ADMINISTRATORS
APPLICATION FOR LICENSURE – CONTINUED

V. EDUCATION RECORD											
1. ARE YOU A HIGH SCHOOL GRADUATE? YES <input type="checkbox"/> NO <input type="checkbox"/>											
2. LIST BELOW EDUCATION BEYOND HIGH SCHOOL											
SCHOOL NAME AND ADDRESS				COURSE OF STUDY		YEARS ATTENDED FROM TO		DID YOU GRADUATE?		LIST DIPLOMA OR DEGREE	
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
								<input type="checkbox"/> YES <input type="checkbox"/> NO			
VI. EMPLOYMENT HISTORY											
1. MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS MAKE INQUIRY OF YOUR PRESENT OR PAST EMPLOYERS? YES <input type="checkbox"/> NO <input type="checkbox"/>											
2. IF YOU HAVE EVER BEEN DISMISSED FROM A POSITION, PLEASE EXPLAIN GIVING DATE, EMPLOYER AND CIRCUMSTANCES. 											
3. LIST ALL PRESENT AND PAST EMPLOYMENT, BEGINNING WITH YOUR MOST RECENT POSITION. IF ADDITIONAL SPACE IS NEEDED, PLEASE MAKE AN ADDENDUM.											
NAME AND ADDRESS OF EMPLOYER								TYPE OF BUSINESS			
POSITION TITLE(S)		FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR					
		MO.	YR.	MO.	YR.						
1.											
2.											
3.											
LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.											
1.						<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME		NUMBER OF HOURS EACH WEEK			
2.						<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME		NUMBER OF HOURS EACH WEEK			
3.						<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME		NUMBER OF HOURS EACH WEEK			

BOARD OF NURSING HOME ADMINISTRATORS

APPLICATION FOR LICENSURE – CONTINUED

NAME AND ADDRESS OF EMPLOYER					TYPE OF BUSINESS	
POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR	
	MO.	YR.	MO.	YR.		
1.						
2.						
3.						
LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.						
1.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
					TIME	
2.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
					TIME	
3.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
					TIME	

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POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR	
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1.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
					TIME	
2.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
					TIME	
3.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
					TIME	

NAME AND ADDRESS OF EMPLOYER					TYPE OF BUSINESS	
POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR	
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LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.		
1.	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
2.	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
3.	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK

NAME AND ADDRESS OF EMPLOYER					TYPE OF BUSINESS	
POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR	
	MO.	YR.	MO.	YR.		
1.						
2.						

LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.		
1.	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
2.	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK

VII. GENERAL

1. NURSING HOME AFFILIATION (IF ANY)			
NAME OF FACILITY		STREET ADDRESS	
CITY	STATE	COUNTY	ZIP CODE
BED CAPACITY	LICENSED BY MO. DIVISION OF AGING? <input type="checkbox"/> YES <input type="checkbox"/> NO	ADMINISTRATOR	
YOUR NAME AS YOU WISH IT TO APPEAR ON LICENSE		THIS DOCUMENT MUST BEAR APPLICANT’S NOTARIZED SIGNATURE	

PLEASE REFER TO THE INSTRUCTION SHEET WHEN COMPLETING THE APPLICATION. THE FOLLOWING ITEMS MUST ACCOMPANY THIS FORM:
1. TWO (2) CURRENT LETTERS OF REFERENCE IN ADDITION TO ANY SUBMITTED BY PRESENT EMPLOYERS.
2. COPY OF BIRTH CERTIFICATE.

3. OFFICIAL COLLEGE TRANSCRIPTS.
4. COPY OF HIGH SCHOOL DIPLOMA (ONLY IF COLLEGE TRANSCRIPT DOES NOT VERIFY).
5. RECENT PHOTO (SNAPSHOT ACCEPTABLE).
6. MONEY ORDER FOR \$100.00 MADE PAYABLE TO THE DEPARTMENT OF HEALTH AND SENIOR SERVICES (NON-REFUNDABLE APPLICATION REVIEW FEE).

I CERTIFY THAT THE ANSWERS I HAVE MADE TO EACH AND ALL OF THE QUESTIONS IN THIS APPLICATION ARE FULL AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.			
SIGNATURE		DATE	
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		
	NOTARY PUBLIC SIGNATURE		MY COMMISSION EXPIRES
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		